tation, a careful survey is made of the medical staff review committee's activity within the hospital. When they are found to be functioning properly, the hospital medical staff is given a certificate of approval by the California Medical Association. If they are not, recommendations are made which point out their weakness and suggestions are made for improvement. Subsequent surveys of the hospital are made by the local committees, and if found to be complying with the standards, a certificate is issued.

What are some of the things that survey teams have already discovered? A credentials committee that does an excellent job in screening the active staff, but does little or nothing concerning the courtesy staff; a records committee that has delegated all its work to one man; or a fine committee of excellent men who never review a file unless the record librarian brings it to their attention; a tissue committee with a most accommodating pathologist; a medical review committee that never looks for anything and never finds anything. We can all think of other situations at which the local survey team might well take a good, hard look.

Refined delineation of quality care is not a practical goal at this time, but certainly control of gross instances of questionable medical care in hospitals is a practical and necessary objective. It is never a pleasant task. Recognizing this and appreciating its importance, the legislature has given a limited privilege or immunity to the members of committees who perform these essential functions.

Each hospital governing board and medical staff should adopt a resolution approving the Guiding Principles. Provision should be made for each member of the medical staff to indicate his willingness to abide by the Guiding Principles. This is usually done by a statement on the application and reapplication form that is signed by the physician when he requests staff privileges.

In the implementation of the Guiding Principles, it is most important that both the governing board and the medical staff be sincere in their desire to abide by them. If earnestness is not exhibited, then there is little use in adopting them. Time is of the essence, and we cannot delay much longer in having every hospital in California adopt these Principles. We have said that only a physician is competent to review the work of physicians. The public expects and the law authorizes to establish and maintain necessary means to judge competence and assure quality care on a voluntary, self-educational and disciplinary basis. If we do not exercise this privilege, it will be forfeited and passed to the state to be administered on a compulsory basis with standards established and enforced by it. I don't believe anybody in this room wants this to happen!

The time has long since gone for merely talking a good game . . . we must demonstrate that we mean business. Our question for today is "to act or react?" I say to react is healthy, provided constructive and sincere action follows.

San Mateo County Dept. of Public Health and Welfare, 225-37th Avenue, San Mateo, California 94403.

The Role of the Medical Staff Hospital Utilization Committee

EDWARD H. CRANE, M.D., Los Angeles*

WHILE REPRESENTING the medical profession over the past years in county medical association work and on hospital boards, I have been reminded repeatedly that the hospital and its staff must work out their problems together. An attempt by either the hospital or the staff to put the other in a subservient role will create problems, not solve them.

The preservation of our hospital standards, our excellence of patient care, and our independence of governmental control will depend directly on future control of hospital costs. Organized medicine, particularly in the Los Angeles County Medical Association, has come to realize that the development of *adequate* health insurance coverage at a reasonable premium cost is a must. It is our firm belief that this can be accomplished by control of abuses, financial participation by the patient through intelligent deductibles, education of all parties concerned, and by properly controlled use of benefits available.

You have heard from Dr. Batchelder regarding the importance of adopting "The Guiding Principles for Physician-Hospital Relationships." In order to inject some certainty into their actual implementation, the survey committees outlined by Dr. Batchelder will be available. However, let me again remind you, these committees can act only if your staff requests their help. Let me make the basic reasons clear to everyone here. In the first place, only doctors of medicine can accurately judge the quality of medical care.

Secondly, the disciplined medical staff of a hospital is the one place where our quality standards are maintained. There is little or no control elsewhere. We are proud of the high standard of medical care in the United States and the physician who willingly judges his fellows, and allows them to judge him, has made this high standard possible. Such conduct and standards are maintained outside the hospital in the practice of each physician in his office. High standards of medical care reflect from the hospital to the private office and back again to the hospital. It is our responsibility to maintain our high stand-

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ards, expand them to all hospitals, and to improve them. The implementation of the "Guiding Principles" will aid us. The assistance of the survey committees will make our job easier . . . sufficient reason, I think, to request their help.

Active participation of the staff in control of patient use of hospital services and supplies is of paramount importance. We cannot deny that some patients stay too long in hospitals, are admitted unnecessarily, have too many x-rays, too much laboratory work, and take home too much hospital prescribed (insurance paid) medication for home use. All this adds up to higher premiums and less adequate health insurance coverage.

The most important first step in correcting this situation is the education of the hospital staff. Many of us who have been working on these problems, forget that the average physician is not as aware of these problems as he should be. It is therefore up to staff leaders to hold meetings and issue communications repeatedly, until they are sure that their staff is knowledgeable. This can be augmented by key men on the staff with constant repetition in the coffee room, dressing rooms, in committee meetings and in the hospital corridors. A willingness on the part of the staff to seek aid and constructive criticism from the survey committees is a must, of course.

At this point, may I indicate to you the necessity of awareness on the part of the staff of the importance of costs in preserving those things we value. We must keep costs in mind when we make executive committee decisions which unnecessarily prolong patient stay merely for the convenience of the hospital or the doctor. Early admission of patients mainly for laboratory work which could easily be done before the patient is admitted, is an example.

After adequate education of your staff, the next step follows easily, with the establishment of a Utilization Committee. This committee will function in much the same manner as the Tissue Committee or the Surgery Committee, with hospital records as the source material. Cases can be referred to this committee from the Surgery, Tissue, Medical and other Committees as indicated.

Specifically, the Committee should devote its attention to these areas:

1. Unnecessary admissions,
2. Excessive length of inpatient stay,
3. Overuse of x-ray, and other diagnostic and therapeutic services, and
4. Delay in transferring convalescent to less expensive accommodations.

In each of these categories, the Utilization Committee can provide answers to such questions as:

1. How many such cases are there?
2. What factors contribute to their existence, and
3. What practical suggestions can be made to the proper authority to avoid these situations?

Diplomacy must be the watchword of this committee, and experience will furnish criterion for proper judgment. The very existence of the committee will have a positive effect. Awareness of the many factors which influence hospital usage will be very important. Types of insurance coverage, attitudes of employee groups, and the differences in individual practice patterns will also be important. We must realize that staff control, so far as usage is concerned, is new. There will be resentment; and, unless the first step of staff education is well done, this resentment could wreck the effort.

If is of great importance that we do not ride roughshod over the practice habits of our staff members! Doctors have habits of practice which are important to them. Disrupting such habits unnecessarily may interfere with good patient care by that doctor. On the other hand, some practice habits are costly and have no value in improved patient care. We will have only to point this out to reasonable physicians to effect an improvement. As an example, a doctor who habitually keeps a mastoid, cataract, or appendix case in the hospital for a certain number of days *routinely* may often be unnecessarily increasing costs. An awareness here will be all that is necessary in most cases to change such a habit. The doctor will then evaluate each case and discharge each patient when he is ready to be discharged and not simply on the basis of a routine number of days.

To repeat, it should be a duty of the Utilization Committee to remind the staff, at frequent intervals, of the importance of transferring convalescent patients to less expensive long-stay institutions. This again is a matter of practice-habit, and the mechanics of accomplishing such transfers should be made easy and obvious.

It is my firm opinion that the staff of each hospital must go further. It must be observant of insurance programs and insurance agents in its community. It was brought to my attention recently that an insurance agent representing a large aircraft company was directing the employees to insist that they be hospitalized for diagnostic purposes, when the insurance program specifically excluded such service. On inquiry by a physician, this agent stated that it was O.K. to go ahead and that the physician would be paid. One can imagine what this will do to the premium structure at the next bargaining table. Information of this sort helps round out the area picture and pinpoint the cures for over-utilization.

Further, each hospital services many large groups of employees. It should be the interest and action of

the staff to approach these industries and employee groups to gain their interest and aid in control of over-utilization. Many of you doctors have had the experience of going in to discharge your patient and have him, or her, request an additional day or two stay. The reasons are usually ones of convenience: "My children bother me," "I will be there alone," etc. These patients almost always have insurance coverage. I find if one explains to them what a day or two extra will do to their future premium cost, and point out to them that theirs is a group coverage and prolonged stay on their part is unfair to the rest of the group, most patients will understand this and be very cooperative.

Responsibility for understanding by the patient must be shared by doctors, employers, insurance companies and labor leaders. In the Los Angeles County Medical Association, we have a committee which I started last year as a President's Committee and which I have been allowed to chair this year as the Planning and Research Committee. This committee is made up of doctors of medicine, top insurance executives, hospital executives, top representatives of employers, the Merchants and Manufacturers Association, and labor. Such a committee can attack all the problems of health care and have some chance of success.

Cooperation of the staff, the hospital, the insurance industry, and the patient is a necessity if we are to succeed in this endeavor. Success will be possible when we all recognize and accept the fact that control of hospital costs and the development of adequate health insurance coverage are interrelated and interdependent.

May I appeal to each of you to take the necessary steps to educate and activate your staff. The rewards will be tremendous!

601 S. Prairie Avenue, Inglewood, California 90301.

Health, Insurance, and Pension Plans for Office and Plant Workers in the West, and in the U.S.*

A Report of the Bureau of Research and Planning, California Medical Association

THE ACCOMPANYING table provides information on the percentage of office and plant workers covered by health, insurance, and pension plans 1) in the West, 2) in other regions of the country and 3) in all areas of the United States.

Although the data are not broken down by State, percentage figures shown for the West provide some clue as to the extent of coverage for workers in California.

It is interesting to note the percentage of workers covered in the West for the selected types of benefits indicated below.

Life Insurance—available to:

95 per cent of the office workers;
91 per cent of the plant workers.

Hospitalization—available to:

85 per cent of the office workers;
91 per cent of the plant workers.

Surgical Expense—available to:

85 per cent of the office workers;
91 per cent of the plant workers.

Medical Expense—available to:

74 per cent of the office workers;
82 per cent of the plant workers.

*Monthly Labor Review, pp. 293-299, March 1963.

A 1962 survey by the Bureau of Labor Statistics, of 80 labor markets, representing 188 Standard Metropolitan Areas in the United States, reveals information on employee coverage under health, insurance and pension plans.

In the West, as in all areas of the country, better than 9 out of every 10 office and plant workers are covered by life insurance plans.

Health care benefits rank second among supplementary benefits provided in the West and for all areas of the country. Better than four out of every five workers are covered for hospitalization and surgical expenses in the West; from 75 to 80 per cent are covered for medical expenses, and 40 to 60 per cent are covered by catastrophe or major medical expense.

Accidental death and dismemberment benefits rank third for plant workers and fifth for office workers.

Retirement pension plans cover 78 per cent of the office workers in the West, and 70 per cent of the plant workers.

Only one per cent of all office workers, and two per cent of all plant workers in the West have no health, insurance, or pension plans. For the United States, these percentages are one and three, respectively.

The data for the Western region cover 11 States; it can be assumed from studies previously made that the proportions of workers covered in California will be higher than those presented above, for several categories of plans.